CHANGES TO 37-395 FOR DECEMBER 1, 2006 RULE HEARING

RULE IV PROVIDER BASED ENTITY SERVICES, REIMBURSEMENT

(3) Provider based entity facilities must bill using revenue code 510 for CPT codes for Evaluation and Management services (E and M codes) and procedural codes ~~with the exception of laboratory services as in ARM 37.86.3007(3)~~ **as per Medicare guidelines in Chapter III and in Appendix 3 of the Uniform Billing Editor. HCPCS/CPT codes must be mapped to the 510 revenue code when the procedure was performed in a provider based clinic setting unless Medicare issued instructions for use of another revenue code**.

(4) Provider based entity professionals must bill using the correct site-of-service so that appropriate payment amounts may be determined as in ARM 37.86.105, 37.86.205, 37.86.506, 37.86.206, and 37.88.606.

(a) Unless otherwise noted, only CPT codes for Evaluation and Management services**, professional components** and procedural codes may be billed for professional reimbursement in provider based entities.

(i) All other billable supplies, injectibles, drugs, imaging, diagnotics, lab, and any other services must be billed under the appropriate revenue code using the provider based entity facility provider number.

37.86.2820 DESK REVIEWS, OVERPAYMENTS, AND UNDERPAYMENTS

(1) Upon receipt of the cost report, the department will instruct the Medicare intermediary to consider Medicaid data when they perform a desk review or audit of the cost report and determine whether a Medicaid overpayment or underpayment has resulted.

(2) **For cost reporting purposes** ~~W~~ **w**here the department finds that an overpayment has occurred, the department will notify the provider of the overpayment.

~~(a) In the event of an overpayment, the department will, within 30 days after the day the department notifies the provider that an overpayment exists, arrange to recover the overpayment by set-off against amounts paid for hospital services or by repayments by the provider.~~

(~~b~~ **a**) If repayment is not made within ~~30~~ **60** days after notification to the provider, the department will make deductions from rate payments with full recovery to be completed within 60 days from the date of the initial request for payment. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment and requests a fair hearing.

(3) **For cost reporting purposes** ~~I~~ **i**n the event an underpayment has occurred, the department will reimburse the provider within ~~30~~ **60** days following the department's determination of the amount.

(a) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefited from either the payment or from a transfer of assets.

(4) Providers aggrieved by adverse determinations by the department may request an administrative review and fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, 37.5.337. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2004 MAR p. 482, Eff. 2/27/04.)

37.86.2947 OUT-OF-STATE INPATIENT HOSPITAL REIMBURSEMENT

(2) Medicaid reimbursement for inpatient services for preferred out-of-state hospitals shall not be made to hospitals located more than 100 miles outside the borders of Montana unless the provider has obtained authorization from the department or its designated review organization prior to providing services. All inpatient services provided in an emergent situation must be authorized within ~~48 hours~~ two working days (Monday through Friday).

(a) Hospitals who have not obtained prior authorization under ARM 37.86.2801(4) may receive DRG reimbursement which is not eligible for cost settlement under ARM 37.86.2803 **except for inpatient psychiatric services as provided in ARM 37-88-101**.

(b) Hospitals providing acute inpatient mental health services must have prior authorization by the department or its designees.

37.86.3009 OUTPATIENT HOSPITAL SERVICES, PAYMENT METHODOLOGY, EMERGENCY VISIT SERVICES

(1) For emergency visits that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901 ~~and meet (1)~~, reimbursement will be based on the ambulatory payment classifications APC methodology in ARM 37.86.3020, (except) ~~for~~ emergency room visits ~~on evenings and weekends for Medicaid clients from birth to 24 months of age~~ with CPT codes 99281 and 99282 will be reimbursed based on ~~clinical fees for APC 00600~~ **the lowest level clinical APC weight**.